Comparison of Benefits

Effective October 1, 2008 – September 30, 2009

(changes are in bold)

	PEEHIP - Traditional Plans (Administered by Blue Cross) Preferred Providers	VIVA Health Plan HMO* (In approved areas only) (Available for Active and Non-Medicare Members Only.)
Preventive Medical	$20 copayment then covered in full	$15 copayment then covered in full
Well Baby Care	$20 copayment per visit (6 visits 1st year; 1 visit/yr. thru age 6; one exam every 2 yrs ages 7 - 18)	$15 copayment then covered in full
Routine Immunizations	$20 copayment then covered in full	$15 copayment then covered in full
Office Care		
Physician's Care	$20 per visit	$15 per visit for primary care. $30 for specialty care. Referrals are no longer necessary.
Lab Procedure	$3 per test	Covered in full (after office visit copayment)
Maternity		
Physician's Care	Covered in full	$30 copayment (initial visit only) then covered in full
Inpatient	$100 hospital copayment	Covered in full after $200 copayment
Hospital Services	$100 copayment per admission	$200 copayment per admission
Outpatient Surgery	$75 copayment	$75 copayment, then covered in full
In-Hospital Care		
Surgeon	Covered in full	Covered in full
Physician Visits	Covered in full	Covered in full
Anesthesiologist	Covered in full	Covered in full
Emergency		
In Area/Out of Area Emergency Room	$25 per visit, accident within 72 hours covered 100%	$50 emergency room visit for facility, waived if admitted within 24 hours; Physician's charges covered at 100%.
Mental Health and Substance Abuse		

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Inpatient	Copayments: Days 1-9 $0, days 10-14 $15, days 15-19 $20, days 20-24 $25, days 25-30 $30. Maximum of 30 days per member per fiscal year at approved facilities. Limit of one substance abuse admission per year and two admissions per lifetime.	Mental Health covered at 50%. Maximum benefit for mental health is 30-day combined maximum for mental health/substance abuse per calendar year. Substance abuse is limited to detox only. Maximum of 3 days/occurrence with 50% coverage.
Outpatient	$10 copayment for up to 20 outpatient visits at approved facilities.	100% coverage after $50 copayment per visit. Subject to 20-visit combined maximum for mental health/substance abuse per calendar year.
Prescription Drugs	(Administered by Express Scripts.) Generic - $5 copayment Formulary (preferred brand name) drugs $30 copayment. Non-formulary (non-preferred brand name) drugs $50 copayment. Approved Maintenance drugs covered for 90-day supply. First fill for a new maintenance drug will be a 30-day supply. **Certain medications have quantity level limits to comply with the FDA guidelines and to ensure drug safety for our members.** **Certain medications are subject to Step Therapy.** **Prior authorizations are required before covered members can receive certain medications.** No benefits available when a non-participating pharmacy in the State of Alabama is used. Out-of-State non-participating pharmacies are paid at the participating pharmacy rate. Members pay difference in cost plus appropriate copayments.	Generic - $12 copayment Brand Name - *$25 preferred brand (formulary) *$45 non-preferred (non-formulary) *When an appropriate grade generic is available and brand name is chosen, the copayment will be the brand name copayment plus the cost differential between the brand and generic drugs. 50% coverage for Mental Health drugs. 90% coverage for self-administered injectibles, bio-technical and biological drugs. $3,000 maximum payment in drug costs, per calendar year, per person. Participating pharmacies only. Mail Order pharmacy is available. Oral contraceptives are covered subject to the appropriate copayment.

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	Pharmacists must dispense generic drug unless physician indicates in longhand writing on the prescription "Do Not Substitute", "Medically Necessary", or "Dispense as Written."	
Other Services		
Out-of-state Coverage for Non-PPO Provider	Major Medical benefits apply - payable at 80% UCR after $100 yearly deductible	Only Emergency and Urgent Care Services and Prescription Benefits available
Out-of-state Coverage for PPO Provider	$20 copayment per visit. Members must use providers participating in the Blue Cross plan of that state.	N/A
Vision Examinations	Not Covered	Covered in full once each 12 months after a $30 copayment with participating provider
Dental	Not Covered	The Dental Plan allows you to seek treatment from any licensed dentist. The plan reimburses a percentage of eligible expenses based on usual, customary and reasonable (UCR) fees. **Beginning October 1, 2008, the VIVA dental benefits will be administered by Delta Dental.** Type I – Preventive & Diagnostic – 100% of UCR Type II – Basic Services – 50% of UCR Type III – Major Services** - 25% of UCR Deductible (applies to Basic & Major Services) - $50 per person/$150 per family Calendar Year Max - $500 **12-month Waiting Period applies to Major Services
Spinal Service & Chiropractic Services	Participating Chiropractor – Covered at 80% of the allowed amount with no deductible. After 12 visits in a calendar year, services are subject to	Limited to 10 visits per calendar year $30 copayment per visit

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	precertification. Non-participating Chiropractor- Covered under major medical at 80% of allowed amount. Member will owe 20% co-insurance, major medical deductible and charges over allowed amount.	
Infertility Services	Benefits for medically necessary infertility services are available for artificial insemination and related services. Benefits for medications for infertility treatment are provided with a 50% copay up to a lifetime maximum payment of $2,500 for PEEHIP per member contract. Members will pay 100% of the medications after the $2,500 lifetime maximum is reached. Benefits are not provided for Assisted Reproductive Technology (ART).	Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's lifetime). Treatment for infertility is not a Covered Service.

** VIVA Health Plan HMO: No referral from a primary care physician (PCP) is required. Members must use participating physicians and specialists. Members must use participating hospitals.*

**Time served on a prior carrier's dental plan with your current employer may be credited towards this plan's waiting periods, subject to Underwriting approval.